

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>001120</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>03/19/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>ASBURY TOWERS HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>102 W POPLAR ST GREENCASTLE, IN 46135</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 000	<p>INITIAL COMMENTS</p> <p>Asbury Towers Health Care Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Survey.</p>	R 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE